STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHIT	NINC	00	COMPL	ETED
		155674	A. BUILD B. WING	UNG		05/27/2	011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			Γ CHARLES ST		
ST CHARLES HEALTH CAMPUS				R, IN47546			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	P:	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000			Ī				
			1				
	This Survey was	for a Recertification and	F00	00	Plan of Correction Text: The		
	State Licensure S	Survey.			submission of this plan of		
		J			correction does not indicate		
	Survey Dates: N	May 23, 24, 25, 26 & 27,			admission by St Charles Heat Campus that the findings and		
	2011	11ay 23, 24, 23, 20 & 27,			allegations contained herein		
	2011				an accurate and true	aic	
	Facility number:	002628			representation of the quality		
	Provider number				care provided to the resident		
					St Charles Health Campus.		
	AIM number: 2	200299110			facility recognizes it's obligat provide legally and medically		
	Survey team:				necesary care and services	to its	
	Liz Harper, RN,	TC			residents in an economic and		
	Carole McDanie				efficient manner.The facility herby maintains it is in substantial		
	Martha Saull, Ri			compliance with the requirements			
	Terri Walters, Ri				of participation for comprehe		
	Terri wanters, Kr	· ·			health care facilities. (for Title		
	Census bed type				18/19 programs)To this end, plan of correction shall seve		
	SNF: 15	•			the credible allegation of		
	SNF/NF: 33				compliance with all state and		
					federal requirements govern		
	Residential: 26				the management of this facil	•	
	Total: 74				is thus submitted as a matter statue only.	OT	
	Census payor typ	ne·			. , .		
	Medicare: 11	y - .					
	Medicaid: 19						
	Other: 44						
	Total: 74						
	Sample: 12						
	Supplemental Sa	ample: 7					
	Residential Sam	-					
	Kesidentiai Samj	pie. 3					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4F6611

Facility ID: 002628

TITLE

PRINTED: 06/14/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155674	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/27/2	LETED
	PROVIDER OR SUPPLIEI			3150 S	ADDRESS, CITY, STATE, ZIP CODE T CHARLES ST R, IN47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	findings cited in 16.2.	es also reflect state accordance with 410 IAC completed 6/6/11 by .N.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4F6611

Facility ID: 002628 If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155674	A. BUIL	DING	00	05/27/2	
		133074	B. WING			03/21/2	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ST CHAE	RLES HEALTH CAM	IDI IS			「CHARLES ST R, IN47546		
					X, 1147 540		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	The facility must co			IAU			DATE
F0272 SS=D	•	prehensive, accurate,					
00-D		oducible assessment of					
	each resident's fur	nctional capacity.					
		ke a comprehensive esident's needs, using the					
		ne State. The assessment					
	must include at lea						
	Identification and o	demographic information;					
	Customary routine						
	Cognitive patterns Communication;	;					
	Vision:						
	Mood and behavio	or patterns;					
	Psychosocial well-	· ·					
	-	ng and structural problems;					
	Continence;	and booth conditions.					
	Disease diagnosis Dental and nutritio	and health conditions;					
	Skin conditions;	nai otatao,					
	Activity pursuit;						
	Medications;						
	Special treatments						
	Discharge potentia	summary information					
	regarding the addi						
		the resident assessment					
	protocols; and						
		participation in assessment.			E 070D		
		ew and record review, the	F02	272	F 272Resident #1 received a order for Occupational Thera		06/26/2011
	,	ensure MDS (Minimum			and has been evaluated and		
	· · · · · · · · · · · · · · · · · · ·	nents were accurate for 1			treated as deemed necessar		
		eviewed for MDS			the therapist.Completion Dat		
		sample of 12. Resident			05/26/2011All residents have		
	#1				potential to be affected by the alleged deficient practice	9	
					therefore through systemic		
	Findings include:				changes stated below the		
		- manago motoravi			campus will ensure it comple	tes	
					MDS assessments		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4F6611

Facility ID:

002628

If continuation sheet

Page 3 of 41

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155674	B. WING		05/27/2011
				TADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		l l	ST CHARLES ST	
ST CHAF	RLES HEALTH CAM	IPUS	l l	ER, IN47546	
(X4) ID	STIMMADAS	TATEMENT OF DEFICIENCIES	ID ID	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
		00 P.M., the clinical	1	accurately.Completion Date	
		nt #1 was reviewed.		06/26/2011An in-service wa	• • • • • • • • • • • • • • • • • • •
				completed concerning ROM	
	_	led, but was not limited		assessments for the nurses	and
	I -	transient ischemic		the MDS Coordinator. Syste	l l
		on, personality disorder		change is the MDS coordinate	
	and osteoarthritis	s. The most recent MDS		will complete a range of mo	
	(Minimum Data	Set Assessment) dated		assessment quarterly and for significant change.Completing	
	5/3/11 indicated	the following for the		Date: 06/26/2011DHS/Des	l l
		of motion: no impairment		will perform audits of 3 rand	
		ity (shoulder, elbow,		residents to assure ROM	
	wrist and hand).	ity (shoulder, cloow,		Assessment are completed	
	wrist and nand).			quarterly and with significar	
	0.5/0.6/11	20.534 4 3.559		changes and coded correct	- I
		00 P.M., the MDS		the MDS 5x weekly x 1 wee	
	coordinator was	interviewed. She was		then 3x weeky x1 month, the weekly with results forwards	
	made aware of th	ne observation of the		the QA Committee monthly	
	resident on 5/24/	11 at 8:30 A.M.		months and quarterly therea	
	regarding the pos	sitioning of the resident's		for review and further	
		eing drawn toward the		suggestions/comments.Cor	npletio
		e hand) and the resident		n Date: 06/26/2011	
		successfully maneuver			
	~	decessiony maneuver			
	eating utensils.				
		21			
		50 A.M., a copy of the			
	rehabilitation sc	reen" was received from			
	the DON (Direct	or of Nursing). This			
	change in status	form was dated 5/26/11.			
	_	: "Screen for possible			
		and Evaluation) needs at			
	· ·	inch - wouldn't attempt to			
		roll. Dinner-held			
		ny difficulty when she			
		l - grabs for food with her			
	handsmay bene	efit from plate guard"			

PRINTED: 06/14/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155674	A. BUI B. WIN	LDING IG		05/27/2	011
		<u> </u>	B. WIN		DDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIE	R		1	CHARLES ST		
ST CHAI	RLES HEALTH CAN	MPUS		JASPER	R, IN47546		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		0:30 A.M., the MDS					
		interviewed. She					
		dn't know when the					
	_	sident's right hand					
		will complete a change					
		S regarding the resident's					
		r right fingers. At this					
	time, the ADON	(Assistant Director of					
	Nursing) indicat	ed they had received a					
	physician order,	dated 5/26/11 for OT					
	(Occupational T	herapy) eval (Evaluation)					
	as indicated for	A and E (Assessment and					
	Evaluation) and	possible right hand					
	positioning devi	ces." At this time, the					
	MDS coordinate	or indicated on the					
	resident's right h	and, her index finger and					
	thumb were with	nout limitation. She also					
	indicated the ren	naining 3 fingers on the					
		and were resting in a					
	1	ppeared pulled to the right					
		and the MDS coordinator					
	1 `	e resident was not able to					
	separate her fing	gers to the full extent.					
		,					
	On 5/27/11 at 10):50 A.M., the DON					
		rsing) was interviewed.					
	`	e facility wanted the					
		independent as possibly					
	with her eating.	matpondent as possion					
	with not cating.						
	On 5/27/11 at 11	A.M., the MDS					
	coordinator prov	vided a current copy of her					
	_	MDS condition change.					
		tion was from the "CMS's					

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PRINTED: 06/14/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155674		A. BUILDING	00	COMP 05/27/2	LETED	
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER		3150 S	T CHARLES ST		
ST CHAF	RLES HEALTH CAM		JASPEI	R, IN47546		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	CTION ILD BE	(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
	(Centers for Med	licare and Medicaid) RAI				
	(Resident Assess	ment Instrument) Version				
		was dated September				
		mentation indicated the				
	-	SCSA (Significant				
	-	Assessment) is a				
	must be complete	essment for a resident that				
	-	Team) has determined				
		eets the significant				
		es for either improvement				
	or decline"					
	3.1-31(a)					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHIT	NINC	00	COMPL	ETED
		155674	A. BUILD B. WING			05/27/2	011
			B. WING	_	DDRESS, CITY, STATE, ZIP CODE	Ь	
NAME OF P	PROVIDER OR SUPPLIER	£			CHARLES ST		
ST CHAF	RLES HEALTH CAM	IPUS			R, IN47546		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	A facility must use						
SS=D		velop, review and revise the					
	resident's compre	hensive plan of care.					
	The facility must d	levelop a comprehensive					
	_	resident that includes					
		tives and timetables to meet					
	•	al, nursing, and mental and					
		ds that are identified in the					
	comprehensive as	ssessment.					
	•	st describe the services that					
		d to attain or maintain the					
	resident's highest practicable physical, mental, and psychosocial well-being as						
		83.25; and any services that					
		e required under §483.25					
	•	ed due to the resident's					
		under §483.10, including the					
	_	tment under §483.10(b)(4).			E 0705		
		ation, interview and	F02	.79	F 279Resident #1 care plans have been reviewed and upon		06/26/2011
	record review, th	e facility failed to ensure			as applicable.Completion Da		
	the resident's pla	n of care was current in			06/06/2011All residents have		
	regard to her diff	ficulty maneuvering			potential to be affected by the	е	
	eating utensils ar	nd/or food in the			alleged deficient practice		
	restorative dining	g room for 1 of 3			therefore through systemic		
	sampled resident	s reviewed for meal			changes stated below the campus will ensure the resid	ent's	
	consumption in t	he restorative dining			care plan is current.Completi		
	_	e of 12. Resident #1			Date: 06/26/2011An in-servi		
	r				was provided concerning car		
	Findings include:				plans for nursing staff. Syste		
	1 mamas merade	•			change is Interdisciplinary Te	am	
	The eliminal mass	rd of Resident #1 was			will update plans of care as changes occur. Completion D)ate:	
					06/26/2011DHS/Designee w		
	reviewed on 5/24/11 at 1:00 P.M. Diagnoses included, but were not limited to, the following: dementia with			perform audits of 3 random			
				residents to assure care plar	າຣ		
				are current in regards to the			
	psychotic feature	es, osteoarthritis, transient			resident's current condition 5		
					weekly x 1 month, then 3x w	eely	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155674	B. WIN			05/27/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				T CHARLES ST		
ST CHAF	RLES HEALTH CAM	1PUS		1	R, IN47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	\	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
0		, and depression. The	+	0	x 1 month, then weekly with		Dille
	·	•			results forwarded to the QA		
		S (minimum data set			Committee monthly x 6 month	ths	
	· /	d 5/3/11 indicated the			and quarterly thereafter for re	eview	
	I -	resident's range of			and further		
	motion: no impa	* *			suggestions/comments.Com	pletio	
	extremity (should	der, elbow, wrist and			n Date: 06/26/2011		
	hand). A total su	ımmary score of 4 for					
	cognition, indica	ted the resident was					
	severely impaired	d.					
	, ,						
	A speech therapy	discharge summary,					
	1 1 11	dicated the following					
	1	erral" "Pt. (patient)					
		• /					
	_	by after recent decline in					
		doing better and desires					
	to eat"						
	1 ^	ated 2/9/11, addressed the					
		m: "ADL (activities of					
	daily living) self-	-care deficitneeds					
	assistance or is d	ependent					
	inEatingInter	ventions included, but					
	were not limited	to, the following:					
		lf-care status changes;					
		t changes in ADL					
		estorative nursing,					
	1 -	only the amount of					
		-					
	_	vision that is needed with					
	ADL'S"						
	, , , , .	10/0/11 11 11					
	1 *	ated 2/9/11, addressed the					
		m: "Alteration in					
	comfort (arthritis	s). Interventions included,					
	but were not limi	ited to, the following:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155674			ULTIPLE COI LDING	NSTRUCTION 00	COMPI	LETED	
		155674	B. WIN			05/27/2	2011
	PROVIDER OR SUPPLIER			3150 ST	DDRESS, CITY, STATE, ZIP CODE CHARLES ST		
ST CHAP	RLES HEALTH CAN			JASPER	R, IN47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	"Assist resident vencourage reside of ordered diet" A Restorative Ca 3/25/11 was revisite indicated the foll Staff cont (conting for AROM (active (bilateral upper eleating). She is procues) et demo (do return). 10 reps (for flexion/extension limited range). She in rest (restorative served mechanical liquids). Her mean given. She will a however it varies et she tolerates detail the following production of the follo	with ADLS as needed, and to consume 75-100% encourage resident to are Progress Note, dated ewed. This entry owing: "Weekly Note: nue) to see res (resident) are range of motion) BUE extremities)et (and) ovided with V.C. (verbal emonstration) she will repetitions) of a exercises. She has the is also eating all meals re) dining room. She is al soft diet with thin all is set up et (and) v.c. attempt self feeding as. Staff assist as needed beliem: "Restorative cumented goal was red self at least 75% of a Interventions included, atted to, the following: up, gives cues and assist as needed with on."					
	On 5/24/11 at 8:3	30 A.M., Resident#1 was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4F6611

Facility ID:

002628

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	LETED
		155674	B. WIN			05/27/2	2U11
	PROVIDER OR SUPPLIER		-	3150 ST	DDRESS, CITY, STATE, ZIP CODE Γ CHARLES ST		
ST CHAF	RLES HEALTH CAM			JASPER	R, IN47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
PREFIX	observed in the R She was sitting a following food ir (uncut), a dish of (uncut), one slice regular, uncovered The resident was her right hand, w between the resident index finger fingers of the resident observed to be st position, pulled t base of the knuck heard to say, as s fried egg with he of it. I can't get it stabbed the edge dangling from on came over to the it in half." After half, the resident and took it to her observed to be ea utensils and a sta adaptive device. At 8:45 A.M., LE #1, "Are you goin LPN #1 took a sr			PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
	then reached for grabbing the end	the standard spoon and of it again with her right finger, tried to takes					
	unumo and muex	iniger, area to takes					

002628

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155674	A. BUI	LDING	00	COMPL 05/27/2	
		155074	B. WIN			03/27/2	011
NAME OF	PROVIDER OR SUPPLIE	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
ST CHAI	RLES HEALTH CAN	/IPUS			Γ CHARLES ST R, IN47546		
				<u> </u>	τ, πτιτο το		075)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	bites of the cerea	al flakes. Resident #1					
		n from the cereal bowl to					
	1	no cereal in the bowl of					
	the spoon for 3 of	of 5 attempts at eating the					
	cereal.						
	On 5/24/11 at 12	2:05 P.M., the Resident					
		the dining room. She					
	was struggling to	pick up her fork with					
	her right hand.	The fingers of her right					
	hand are position	ned in a fanning manner					
	to the right of he	er palm. CNA #7 stated					
	"I'm going to hel	lp you" and came over to					
	the resident and	began feeding her. CNA					
	#7 did not encou	rage the resident to eat					
	independently by	ut fed the resident.					
	On 5/26/11 at 10	0:00 A.M., the DON					
	(Director of Nur	sing) was interviewed.					
	She indicated sh	e did not find					
	1	where the therapy					
	1 -	assessed the resident					
	regarding her ea	ting/self feeding skills.					
		30 P.M., the DON was					
	1	e indicated they had					
		cian office to get an order					
	for therapy to ev	aluate the resident.					
	0.5/2-1/1	50.435					
		50 A.M., a copy of the					
		creen" was received from					
	`	tor of Nursing). This					
	1 -	form was dated 5/26/11.					
	Findings include	ed: "Screen for possible					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or connection	155674	- 1	LDING	00	05/27/2	
		100011	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2		1	T CHARLES ST		
ST CHAI	RLES HEALTH CAN	MPUS		1	R, IN47546		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	_	TAG	DLI ICILIAC I)		DATE
	`	and evaluation) needs at unch - wouldn't attempt to					
		y roll. Dinner-held					
		ny difficulty when she					
		d - grabs for food with her					
		efit from plate guard"					
	inanasinay beni	on nom place guaru					
	On 5/27/11 at 10	0:30 A.M., the MDS					
	coordinator was	interviewed. She					
	indicated she did	In't know when the					
	change in the res	sident's right hand					
	occurred but she	will complete a change					
	in condition MD	S regarding the resident's					
	limitations in her	r right fingers. At this					
	time, the ADON	(Assistant Director of					
	Nursing) indicat	ed they had received a					
	physician order,	dated 5/26/11 for OT					
	(occupational the	erapy) eval (Evaluation					
	and Treatment) a	as indicated for A and E					
	(assessment and	evaluation) and possible					
	right hand positi	oning devices." At this					
		oordinator indicated on					
	_	ht hand, her index finger					
		without limitation. She					
		e remaining 3 fingers on					
	_	ht hand were resting in a					
	· -	ppeared pulled to the right					
		and the MDS coordinator					
		e resident was not able to					
	separate her fing	ers to the full extent.					
	On 5/27/11 at 10	0:50 A.M., the DON					
	(Director of Nur	sing) was interviewed.					
	She indicated the	e facility wanted the					

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155674	B. WING		05/27/2011
	PROVIDER OR SUPPLIER		3150 ST	ADDRESS, CITY, STATE, ZIP CODE F CHARLES ST R, IN47546	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	resident to be as with her eating. 3.1-35(a)	independent as possibly			
F0310 SS=D	a resident, the factoresident's abilities not diminish unles individual's clinical diminution was unthe resident's ability groom; transfer and use speech, langue communication sy. Based on observative record review, the plan and implement resident to remain possible in skills sampled resident consumption in the sample of t	ation, interview and e facility failed to assess, ent care to assist a n as independent as for eating for 1 of 3 s reviewed for meal the restorative dining e of 12. Resident #1	F0310	F 310 Resident #1 has been evaluated by therapy and a plan of care has been initiated to assist her to remain as independent as possible in skills for eating. Completion Date 05/26/2011 All residents have the potential to be affected by the alleged deficient pratherefore through systemic changes stated below the campus will ensure residents remain as independent as possible.	ne ne nectice

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155674 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3150 ST CHARLES ST ST CHARLES HEALTH CAMPUS JASPER, IN47546 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Completion Date 06/26/2011 The clinical record of Resident #1 was reviewed on 5/24/11 at 1:00 P.M. Diagnoses included, but were not limited to, the following: dementia with An in service was completed with nursing staff related to assisting residents psychotic features, osteoarthritis, transient to remain as independent as possible. All ischemic attacks, and depression. The staff has been in serviced on the therapy communication tool. Systemic change is most recent MDS (Minimum Data Set) initiation of a therapy communication for assessment, dated 5/3/11, indicated the all staff to use to notify therapy of a following for the resident's range of change noted in a resident. Completion Date 06/26/2011 motion: no impairment for upper extremity (shoulder, elbow, wrist and DHS/designee will perform audits of 3 hand). A total summary score of 4 for random residents to assure residents have been assessed and the plan of care is cognition, indicated the resident was implemented to assist residents to remain severely impaired. as independent as possible 5x week x one month then 3x a week x one month then weekly with results forwarded to QA A speech therapy discharge summary, committee monthly x 6 months and dated 1/12/11, indicated the following quarterly thereafter for review and "Reason for Referral" "Pt. (patient) further suggestions/comments Completion Date 06/26/2011 referred to therapy after recent decline in status. Pt is not doing better and desires to eat..." A plan of care, dated 2/9/11, addressed the following problem: "ADL (activities of daily living) self-care deficit...needs assistance or is dependent in...Eating...Interventions included, but were not limited to, the following: Assess/record self-care status changes; report significant changes in ADL status...provide restorative nursing, eating...provide only the amount of assistance/supervision that is needed with ADL'S..."

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AND PLAN	OF CORRECTION	155674	A. BUI	LDING	00	05/27/2	
		155074	B. WIN		PRESIDENCE CONTROL CON	03/21/2	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE T CHARLES ST		
ST CHAF	RLES HEALTH CAM	IPUS			R, IN47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
IAU	A plan of care, da following probles comfort (arthritis but were not limi "Assist resident vencourage resident of ordered diet" A Restorative Ca 3/25/11, indicated Note: Staff cont (resident) for AR motion) BUE (bi extremities)et (provided with V. demo (demonstrareps (repetitions) exercises. She ha also eating all med dining room. She soft diet with thir up et (and) v.c. g self feeding hower as needed et she in A plan of care, da the following pro Dining." The document of the provided with the provided with the provided with thir up et (and) v.c. g self feeding hower as needed et she in the following pro Dining." The document of the provided with thir up at (and yet) as needed et she in the following pro Dining." The document of the provided with the	ated 2/9/11, addressed the m: "Alteration in b). Interventions included, ted to, the following: with ADLS as needed, not to consume 75-100% encourage resident to are Progress Note, dated d the following: "Weekly (continue) to see res OM (active range of lateral upper and) eating. She is C. (verbal cues) et (and) ation) she will return. 10 of flexion/extension as limited range. She is eals in rest (restorative) e is served mechanical in liquids. Her meal is set iven. She will attempt ever it varies. Staff assist		IAG	DEPALENCY)		DAIE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155674		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 05/27/2011	
NAME OF PROVIDER OR SUPPLI		STREET A 3150 S	ADDRESS, CITY, STATE, ZIP COI T CHARLES ST R, IN47546	DE		
PREFIX (EACH DEFICE	STATEMENT OF DEFICIENCIES ENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
encourage to e	at, assist as needed with ion."					
observed in the She was sitting following food (uncut), a dish (uncut), one sli regular, uncover The resident wher right hand, between the reright index fing fingers of the robserved to be position, pulled base of the knu heard to say, as fried egg with of it. I can't get stabbed the edg dangling from came over to the it in half." Aft half, the reside and took it to hobserved to be utensils and a sadaptive device. At 8:45 A.M., #1, "Are you g	Restorative Dining room. at the table with the in front of her: fried egg of dry cereal, a Danish roll ce of toast and a standard, ered glass of orange juice. as observed with a fork in with the handle of the fork sident's right thumb and ger. The remaining three esident's right hand were straight but in a slanted I to the right, starting at the ckle. The resident was a she was stabbing at her her fork, "I can't get ahold it." The resident had ge of the egg, with it one fork tine. LPN #1 he table and stated, "I'll cut er the fried egg was cut in hit was able to spear the egg er mouth. The resident was eating with standard tandard plate without any characteristics."					

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AND PLAN	OF CORRECTION	155674	A. BUI	LDING	00	05/27/2	
		100074	B. WIN		DDDEGG CITY CTATE TID CODE	03/21/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE T CHARLES ST		
ST CHAF	RLES HEALTH CAM	IPUS		1	R, IN47546		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	poured it over the	e dry cereal. Resident #1					
	then reached for	the standard spoon and					
	grabbing the end	of it again with her right					
	thumb and index	finger tried to takes bites					
	of the cereal flak	es. Resident #1 moved					
	the spoon from the	ne cereal bowl to her					
	mouth with no ce	ereal in the bowl of the					
	spoon for 3 of 5	attempts at eating the					
	cereal.						
		:05 P.M., Resident #1					
		the dining room. She					
	""	pick up her fork with					
	_	The fingers of her right					
	_	oned in a fanning manner					
		r palm. CNA #7 stated,					
	"	p you," and came over to					
		began feeding her. CNA					
		rage the resident to eat					
	independently bu	it fed the resident.					
	0.5/0.6/11 . 10	ANG A DOM					
	On 5/26/11 at 10						
	l `	sing) was interviewed.					
	She indicated she						
	documentation w						
	_	issessed the resident					
	regarding her eat	ing/self feeding skills.					
	On 5/26/11 at 1:3	30 P.M., the DON was					
		e indicated they had					
		ian office to get an order					
		aluate the resident.					
	101 merapy to eve	aradio the restdent.					
	On 5/27/11 at 6:5	50 A.M., a copy of the					

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AND PLAN	OF CORRECTION	155674	A. BUI	LDING	00	05/27/2	
		100074	B. WIN		PRESIDENCE CONTROL CON	03/21/2	011
NAME OF	PROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STATE, ZIP CODE CHARLES ST		
ST CHAI	RLES HEALTH CAN	1PUS		1	R, IN47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ereen" was received from					
	`	or of Nursing). This					
	1 ~	form was dated 5/26/11.					
	1 -	: "Screen for possible					
	`	and evaluation) needs at					
	1	ınch - wouldn't attempt to					
	1	y roll. Dinner-held					
		ny difficulty when she					
	has it in her hand	d - grabs for food with her					
	handsmay benefit from plate guard"						
		2:30 A.M., the MDS					
	coordinator was	interviewed. She					
	indicated she did	ln't know when the					
	change in the res	sident's right hand					
	occurred but she	will complete a change					
	in condition MD	S regarding the resident's					
	limitations in her	r right fingers. At this					
	time, the ADON	(Assistant Director of					
	Nursing) indicate	ed they had received a					
	physician's order	, dated 5/26/11, for OT					
	(Occupational T	herapy) eval (evaluation)					
	as indicated for A	A and E (Assessment and					
	Evaluation) and	possible right hand					
	positioning device	ces." At this time, the					
	MDS coordinato	r indicated on the					
	resident's right h	and, her index finger and					
	thumb were with	out limitation. She also					
	indicated the ren	naining three fingers on					
	1	ht hand were resting in a					
	1	opeared pulled to the right					
	1	and the MDS coordinator					
	1 '	e resident was not able to					
	separate her fing	ers to the full extent.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155674	B. WIN		-	05/27/2	011
ST CHAF	PROVIDER OR SUPPLIER			3150 ST	ADDRESS, CITY, STATE, ZIP CODE CHARLES ST R, IN47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	rE	COMPLETION
F0312 SS=D	On 5/27/11 at 10 (Director of Nurs She indicated the resident to be as with her eating. 3.1-38(a)(2)(D) A resident who is a of daily living received to maintain good repersonal and oral Based on observating interview the factincontinent care residents in a same Findings include The clinical recorreviewed on 5/23 4/05/11 Minimu (MDS) indicated frequently incomplan for skin protresident was to be every two hours approvided after each of the same provided after each of the	ation, record review and ility failed to provide for 1 of 5 incontinent inple of 12. Resident # 33 : rd of Resident #33 was 8/11 at 2:10 P.M. The im Data set Assessment	F0	312	F 312 Resident #33 suffered no ill effects alleged deficient practice. Completion Date 06/26/2011 All incontinent residents have the potential to be affected by the allege deficient practice and through chan provision of care and inservicing we prevent the recurrence of the deficient practice. Completion Date 06/26/2 An in service was completed for nu staff concerning residents receiving incontinent care to have proper procedure followed. Systemic change includes all caregivers to complete demonstration of all incontinent care skills. Completion Date 06/26/2011 DHS/designee will perform audits random residents who are incontined.	ed ges in ill ient 2011 arsing g ge return re	DATE 06/26/2011

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∥ `		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155674	B. WIN			05/27/20	J I I
NAME OF	PROVIDER OR SUPPLIEF	t		1	ADDRESS, CITY, STATE, ZIP CODE		
ST CHAI	RLES HEALTH CAN	1PUS			Γ CHARLES ST R, IN47546		
				L	τ, πτη στο		(115)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	P.M., CNA #8 at	nd CNA #9 were			compliance 5x week x one month the	hen	
	1 '	e for Resident #33.			3x a week x one month then weekly		
	1 1 0	at this time, CNA #8			results forwarded to QA committee monthly x 6 months and quarterly		
	_ ~	re going to reposition her.		thereafter for review and further			
		rs now." The resident			suggestions/comment		
	was lying on her	left side in the bed with a			Completion Date 06/26/2011		
		against her back to					
	maintain her pos	ition. CNA #8 asked the					
	resident if she ne	eeded to go to the					
	bathroom, to wh	ich the resident replied					
	she did not. CN.	A #8 replied, "Well then,					
	we'll get you rep	ositioned." The CNAs					
	rolled the resider	nt onto her back and then					
	onto her right sic	le with pillow bolstered					
	against her back	to maintain her position					
	on that side. CN	A #8 was interviewed					
	and indicated the	e resident did wear					
		s. After being made					
		nt had not been checked					
		, she proceeded to check					
		A #8 pulled down the					
		and quickly checked the					
		or strip. The visibility of					
		s occluded by the					
	1	which were not pulled					
	down below the						
		ellow. She's dry." At that					
		ation with improved					
	-	quested, and the strip was					
		from front to back. CNA					
		resident was actually wet,					
		cator was blue. The blue					
		vas consistant with a					
	moderate amoun	t of incontinent urine					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	_{IG} 00		COMPL	ETED
		155674	B. WING		05/27/2011		
	PROVIDER OR SUPPLIER		3	TREET ADDRESS, 150 ST CHAR ASPER, IN478			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	П)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	FIX (EAC	H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRIAT	re I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Tz	AG	DEFICIENCY)		DATE
		oiled brief. CNA #8 and d appropriate skin re.					
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the ir demonstrates that a resident having precessary treatment healing, prevent in sores from develop Based on observative record review, the residents at risk for sores and/or with assessed in a time preventative mean residents reviewed and/or at risk for areas in a sample Resident #30, Refindings include 1. The clinical refined was reviewed on	ation, interview and e facility failed to ensure for developing pressure a pressure sores were ely manner and had assures in place for 2 of 4 ed with pressure areas developing pressure e of 12.	F0314	press Residuasse of disturbed was areas 05/24 #30) (Residual the palleg through and in ensured deversion areas 06/20 been ulcer chan	4Resident #30 has a sure reducint cushion. dent #33 had a head to ssment completed a the scovering area. The resifree of any other s.Completion Date: 4/2011 (Resident 04/18/20 ident #33)All residents hotential to be affected bed deficient practice and gh altercations in proce n-servicing the campus re measures to prevent lopment of pressure s.Completion Date: 6/2011Nursing staff have in-serviced on pressure prevention. Systemic ge is upon admission a sure reducing cushion w	time dent 11 nave y the desses will the	06/26/2011

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li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155674	A. BUI	LDING	00	05/27/20	
		155674	B. WIN			03/2//20	' '
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
ST CHAF	RLES HEALTH CAM	IPLIS		1	Γ CHARLES ST R, IN47546		
					τ, πτη στο		Q15)
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	1.	
	`				CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re i	
(X4) ID PREFIX TAG	to, the following: replacement and The admission M. Assessment), dat following for the cognition; at risk sores; one unstag (known but unstate of wound bed by skin ulcer and tree reducing device of the resident was on 5/13/11. An addated 5/13/11, intransfers and ambassistance; weight cognition, confus occasionally received left knee pain; not present; pressure and bed; no evide insufficiency; skin but not limited to relieving device in with positioning heels off surface; in bed and chair.	in plan of care included provide pressure in chair and bed; assist in bed and chair; elevate assist with positioning		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	gnee f g th, en d to	(X5) COMPLETION DATE
		red 5/13/11 at 3:30 P.M., owing: "left lower					
		immobilizer on while					
	up"						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155674	A. BUI	LDING	00	05/27/2	
		100074	B. WIN		DDDDGG GITH GTATE TID GODE	03/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE T CHARLES ST		
ST CHAF	RLES HEALTH CAM	IPUS		1	R, IN47546		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\neg	ID	PROVIDERIC DI ANI DE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	An "Assessment	Review and					
	Considerations"	form dated 5/16/11					
		owing: "This resident					
	·	grisk factors that may					
		breakdown: mobility					
	_	dical diagnosis affecting					
	1	diabetes, LTKR (left					
	1	ement)weekly skin					
	`	nts)Pain Riskmedical					
	diagnosisrecent surgery (LTKR)						
	A Skilled Nursing Assessment and Data						
	l .	dated 5/17/11, indicated					
	· ·	skin impairment: surgical					
	wound."	ann impunition. Suigivui					
	On 5/19/11 a "Pr	essure/Stasis/Diabetic					
	Ulcer Assessmen	t" form indicated the					
	following: Initia	l identification date					
	5/19/11; area not	present on admission;					
	right heel pressur	re area; unstageable;					
	length 2.0 cm (ce	entimeters) width 2.0 cm					
	and depth under	0.1 cm; treatment right					
	heel off load bil ((bilateral) heels while in					
	bed, right heel le	ft boot on while in bed.					
	On 5/23/11 duris	ng initial tour of the					
		A.M., the resident was					
	1	oom in his wheelchair					
		re reducing cushion.					
	minout a prossur	o reading easinon.					
	On 5/24/11 the r	esident's care was					
	observed from 7:	40 A.M. until 12:20 P.M.					
	The resident was	observed with an					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155674	B. WIN			05/27/2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			3150 S	T CHARLES ST	
	RLES HEALTH CAN				R, IN47546	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	immobilizer to h	•				
		ended from above the left				
	l "	re the left ankle area. The				
		eted and placed in his				
		5 A.M., without a				
	pressure reducing					
		At 8:20 A.M., the				
	resident was whe	eeled to the dining room.				
	The resident rem	ained in his wheelchair				
	and was pushed t	to the therapy department				
	at 9:15 A.M. Th	e resident remained in his				
	wheelchair in the	therapy department until				
	he was observed	in his room, still in his				
	wheelchair at 11:	:15 A.M.				
	On 5/24/11 at 11	:20 A.M., PT (Physical				
		s interviewed. She				
		d cared for Resident #30				
		ated the resident had not				
	I -	therapy but only worked				
	1	y while in the therapy				
		nad remained in his				
	wheelchair.	iad remained in ins				
	wheelchail.					
	On 5/24/11 of 11	.15 AM CNIA #5 amd				
		:45 A.M., CNA #5 and				
	CNA #6 were int	•				
	1	id not provided any care				
		ince toileting him prior to				
	breakfast.					
	On 5/24/11 at 12	:45 P.M., the resident				
		observed with first				
	position change s	SHICE 0.13 A.IVI.				

l	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155674	(X2) MULTIPLE CC A. BUILDING B. WING	00	1 1	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		3150 S	ADDRESS, CITY, STATE, ZIP (T CHARLES ST R, IN47546	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	right heel was ob	250 P.M., the resident's asserved. The right heel have a grayish cast to it was not observed.				
	the facility's poli "pressure preven received from the procedure was un purpose of this p "To maintain good avoid developmed Procedure: Care be implemented identified in the Interventions mal limited to:Proto neededobtain a reduction cushion heels off the bed On 5/27/11 at 8:0 (Director of Nurse copy of the facility for "Weekly Skir This policy and p This policy included, the following	O7 A.M., the DON sing) provided a current ty policy and procedure a Assessment Guideline." procedure was dated 4/08. ded, but was not limited to the				
	the nursing assist for areas of impa- daily dressing an	ant by the licensed nurse tant shall observe the skin irment with bathing and d pericare and notify the s identified." The DON				

	li ´			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155674	B. WIN			05/27/2	UTI
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
ST CHVE	RLES HEALTH CAM	IDLIC		1	T CHARLES ST R, IN47546		
			_		K, IN47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		wed at this time. She	+	IAG			DATE
		dent had been admitted					
		5/13/11 and wasn't yet					
		skin assessment. She					
	indicated the staf	•					
	ongoing skin ass	essinents.					
	2 The 1505001	and affinitely #22					
	2. The clinical record of Resident #33						
		5/23/11 at 2:10 P.M.					
	Diagnoses included, but were not limited						
	to, the following: degenerative joint						
		, osteoporosis and					
		The most recent MDS,					
	· ·	icated the following for					
		erely impaired cognition;					
		ired extensive assistance;					
		or pressure sores; no					
	unhealed pressur						
	_	for chair, bed and					
	turning and repos	sitioning program.					
	A plan of care, da	ated 3/28/11, addressed					
	the following pro	blem: "skin condition."					
	Interventions inc	luded, but were not					
	limited to, the fol	llowing: Assess/record					
	changes in skin s	tatus." The intervention					
	"prevent pressure	e to area" was not					
	checked as an int	ervention.					
	A Change in Con	dition Form, dated					
	_	d the following: "Res					
	•	o blood blisters to back					
	of right lower leg						
		•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155674		LDING	00	05/27/2	
		100074	B. WIN		A DDDEGG CITY CTATE 7ID CODE	00/21/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE T CHARLES ST		
ST CHAF	RLES HEALTH CAM	IPUS		1	R, IN47546		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\neg	ID	PROVIDERIC DI ANI DE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		by progress report, with					
	the period from 3/29/11 to 4/4/11,						
		owing for bed mobility:					
	· ·	and transfers sit/supine					
	with max assist o	of 1 -2.					
	A "Change in co	ndition form" dated					
	_	I the following: "Res has					
		sure area blackened to R					
	heel"						
	A "Pressure/Stasis/Ulcer Assessment"						
	had an initial date	e of 4/18/11, for the					
	location of the rig	ght heel. This form					
	indicated this are	a was not present on					
		of "E (non-stageable due					
		present), length 2.0,					
	width 2.0 and dep	`					
		as defined)." The most					
		ent for this area was					
	1	gth 1.0 cm, width 1.0 cm					
	_	0.1 cm; wound margins					
	intact and surrou	nding tissue "pink."					
	Another plan of o	care, dated 4/19/11,					
	1 *	oblem of "alteration in					
	_	B (as evidenced by)					
	1 .	(right) heel stage E					
	1 ^	entions included. but					
	l ` ′	to, the following:					
	"Examine skin da	aily for signs of redness,					
		ssess areas prone to					
	breakdown espec	eially over bony					
	prominenceturr	n and reposition every 2					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4F6611

Facility ID:

002628

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155674		(X2) MULTIPLE CO A. BUILDING B. WING	00	` ′	E SURVEY PLETED (2011	
	PROVIDER OR SUPPLIEF		3150 S	ADDRESS, CITY, STATE, ZIP C T CHARLES ST R, IN47546	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	reviewed with the form indicated the skin assessment 4/19/11. For the "2" was docume form indicated "the Treatment Recompleted" was On 5/23/11 at 1:: right heel was obtained was open with the theorem indicated "the Treatment Recompleted" was On 5/23/11 at 1:: right heel was obtained was open with the theorem indicated "the treatment at 1:: right heel was obtained was open with the theorem indicated the theorem indi	tecord for April 2011 was be clinical record. This he resident had a weekly on 4/12/11 and then on 4/19/11 assessment, a need, which from the existing" area. Also on ecord, a "skin check documented on 4/18/11. 50 P.M., the resident's poserved. The area was be size of a 5 cent coin with well defined edges. 2:40 A.M., the DON was be indicated for both d #33, the pressure areas and at an unstageable				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155674 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3150 ST CHARLES ST ST CHARLES HEALTH CAMPUS JASPER, IN47546 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must ensure that it is free of F0332 medication error rates of five percent or SS=E greater. F 332 F0332 06/26/2011 Based on observation, record review and interview, the facility failed to ensure a Resident #45, #25, #39, #17 and #9 medication error rate of less than 5%. suffered no ill effects Completion Date 05/24/2011 Nine residents were observed receiving medications. Five errors in medication adminisistration were observed during 49 All residents have the potential to be affected by the alleged deficient practice opportunities for error in medication and through altercations in processes and administration. This resulted in a in servicing the campus will ensure medication error rate of 10.2%. This measures to prevent medication errors Completion Date 06/26/2011 deficient practice affected 2 of 2 residents observed receiving medications in a Nursing staff have been in serviced on sample of 12 and 3 of 4 in a supplemental medication orders regarding passing sample of 7. Resident #45, Resident #39, medications Systemic change is all nurses and QMAs will complete a Resident #17, Resident #25, Resident #9 medication pass competency now and annually thereafter. Completion Date 06/26/2011 Findings include: 1. On 5/24/11 at 8:25 A.M., LPN #2 Nurse managers will observe medication began to prepare oral medications for pass on 5 random residents 5x week x Resident #39. LPN#2 indicated this one month 3x a week x one month then resident was prone to having a gagging weekly with results forwarded to QA committee monthly x 6 months and reflex when taking oral medications. LPN quarterly thereafter for review and #2 indicated she needed to crush the further suggestions/comments resident's oral medications for Completion Date 06/26/2011 administration. LPN #2 at this time crushed the following medications: aspirin 81 mg, Atenolol 25 mg, Namenda 5 mg, Pepcid 40 mg and Wellbutrin SR (sustained release) 150 mg. She then administered these crushed oral medications to Resident #39.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155674		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE D5/27/2011		ETED			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/21/2	•
NAME OF I	PROVIDER OR SUPPLIER	8			T CHARLES ST		
ST CHAI	RLES HEALTH CAN	/IPUS		JASPE	R, IN47546		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	REGULATORT OR	LISC IDENTIFTING INFORMATION)		IAG			DATE
	The 2010 Nursir	ng Spectrum Drug					
	Handbook page 163, indicated the drug						
		sustained release)					
	"Administration						
	sustained-release	e tablets should be					
	swallowed whol	e and not crushed or					
	chewed"						
	On 5/25/11 at 9:55 A.M., the Director of						
	Nursing (DON) provided facility						
		ntitled, "Medications Not					
		This documentation					
		dication Wellbutrin SR.					
		ted the physician was at					
	I -	vening and had now					
	1 -	r the resident to receive Vellbutrin SR crushed.					
	l life infedication v	venoutin SK crusiled.					
	2. On 5/24/11 at	t 11:05 A.M., LPN #2					
		ent # 45 had a accucheck					
	(blood sugar test	e) ordered for 11:00 A.M.					
	I .	rformed the accucheck					
	and documented	a blood sugar number of					
	343. LPN #2 inc	dicated at this time she					
	would not admir	nister the sliding scale					
	insulin ordered f	or the blood sugar of 343					
	· ·	sugar) until after the					
	resident had con	pleted her lunch.					
	Daview of David	ant #451a assert					
		ent #45's current					
		rs at this time indicated					
		but were not limited to:					
	I msumi Novolog	Flexpen S/S (sliding					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL	
THETETAL	or conduction	155674		LDING		05/27/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				T CHARLES ST		
ST CHAF	RLES HEALTH CAM	IPUS		JASPEI	R, IN47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		t 8:00 A.M., 11:00 A.M.,		IAG			DATE
	"	:00 P.M. BS (blood					
	sugar) ranges for sliding scale insulin						
	were: 71-150= 0 units, 151-200 = 1 unit,						
		s, $251-300 = 3$ units,					
		s, $351-400 = 5$ units, if >					
		physician telephone order					
	l .	dicated to discontinue					
	· ·	cale insulin dosage and					
	start sliding scale Novolog to $200-250 = 4$						
	units, 251-300 =	6 units, 301-350= 8					
	units, and 351- 400 = 10 units.						
	On 5/24/11 at 1:3	30 P.M., LPN #2					
	indicated she was	s going to administer the					
	"	alin for the 11:00 A.M.,					
		At his time LPN #2					
		8 units of Novolog					
	insulin.						
	On 5/26/11 at 8:5	50 A.M., during interview					
		ne indicated sliding scale					
		given as ordered at time					
	of accucheck.						
	2 On 5/24/11 -4	2.45 D.M. I DNI #1					
		3:45 P.M., LPN #1					
		s going to pass afternoon					
	· ` `	0 P.M. and 5:00 P.M.). 55 P.M., Resident #17					
		Tramadol (pain) 50 mg					
		7/24/11 at 4:10 P.M.,					
		inical record regarding					
	physician medica	• •					
	reviewed. An or						
	1 = 3 : 10 : : 34: 1 111 01						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155674		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/27/2011			
	PROVIDER OR SUPPLIER		D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CHARLES ST R, IN47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	daily for anemia to be ordered. D time, in regard to administered with P.M. and 5:00 P. planned, LPN #1 missed this media. Resident # 17 that Ferrex medication medication at thi 4. On 5/25/11 at observed administered administered that econcern during a The nurse indicates she omitted administered the resident with the resident had finished breat indicated she undigirls are, sometim (medications) all administered the with the rest of that 9:45 A.M. The clinical recorreviewed on 5/25	at 5:00 P.M., was noted uring interview at this the Ferrex not being hall the resident's 4:00 M., medications as indicated she had cation. LPN #1 then told at she hadn't given her the n and administered the stime. 9:45 A.M., LPN #2 was stering medications to the LPN was informed expressed an omission 9:00 A.M. interview. Sted she had not realized inistration of Prilosec DO A.M. The LPN esident, who indicated before breakfast (which round 8:30 A.M.) and she lafast "long ago." She derstood how "busy the nes have to give them together." The nurse Prilosec OTC 20 mg ne morning medications and of Resident #25 was hard of Resident #25 was hard of Resident #25 was hard of Resident for the hysician order for					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155674			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/27/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN47546				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
		mg at 7:00 A.M., daily.					
	Edition Nurse's I	ence book PDR 2011 Drug Handbook page 871 c should be taken before					
	observed administ Resident #9. Alc 3:00 P.M. medic dose of Famotid clinical record w 4:00 P.M. There 12/09/10 for fam	3:15 P.M., LPN #1 was stering medication to ong with the scheduled ations she also gave a ine 20mg by mouth. The as reviewed on 5/24/11 at was a physician order otidine 20mg (for control) orally, upon rising and					
F0333 SS=D		nsure that residents are ant medication errors.					
	record review, the sliding scale insuting timely manner for reviewed for slid administrations a medication order.	ation, interview, and e facility failed to ensure alin was administered in a or 2 of 3 residents ing scale insulin and an oral laxative requency change was eater than a 2 month	F0333	F 333Resident #45, #4, and suffered no ill effects and the MAR was changed to reflect current order. Completion Da 05/24/2011All residents have potential to be affected by the aleged deficient practice and through altercations in process and in-servicing the campus ensure measures to prevent medication errors. Completio	the tte: e the e ssses will		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155674	B. WIN			05/27/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				T CHARLES ST		
ST CHAF	RLES HEALTH CAM	IPUS		1	R, IN47546		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	period for 1 of 5	residents reviewed for			Date: 06/26/2011Nursing sta	aff	
	constipation med	lication. The deficient			have been in-serviced on medication orders regarding		
	practice affected	3 residents in a sample			passing medications and		
	of 12 and a suppl	lemental sample of 7.			transcription of medication		
	Resident #45, Re	esident #4, Resident #16			orders/lab orders. Systemic		
	,	,			change is physician orders		
	Findings include				transcribed to the medication		
		•			administration sheet or treatr administration sheet will be	ment	
					reviewed by the DHS/Design	iee	
	1. On 5/24/11 at 11:05 A.M., LPN #2				All nurses and QMAs will		
		-			complete a medication pass		
		ent # 45 had a accucheck			competency now and annual	lly	
	I	ordered for 11:00 A.M.			thereafter.Completion Date:		
	_	ed the accucheck and			06826/2011Nurse Managers	Will	
		ood sugar number of 343.			perform random audits of medication administration sh	eets	
	LPN #2 indicated	d she would not		and treatment administration			
	administer the sli	iding scale insulin			sheets to review for medicati		
	ordered for the b	lood sugar of 343			errors or missed labs on 5		
	(elevated) until a	fter the resident had			random residents 5x weekly	I	
	completed her lu	nch.			month, then 3x weekly x 1 m then weekly with results	ontn,	
					forwarded to the QA Commit	tee	
	Review of Resid	ent #45's current			monthly x 6 months and qua	I	
	physician's order	rs at this time indicated			thereafter for review and furt	I	
	1	but were not limited to:			suggestions/comments.Com	pletio	
	1	Flexpen S/S (sliding			n Date: 06/26/2011		
	1	t 8:00 A.M., 11:00 A.M.,					
	1	:00 P.M. BS (blood					
	1	sliding scale insulin					
	1	units, 151-200 = 1 unit,					
		s, $251-300 = 3$ units,					
		s, $351-400 = 5$ units, if >					
		physician telephone order					
	· ·	dicated to discontinue					
		cale insulin dosage and					
	start sliding scale	e Novolog to 200-250 = 4					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155674		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING B. WING (X3) DATE SURV COMPLETED 05/27/2011			ETED		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER	₹		1	T CHARLES ST		
ST CHAI	RLES HEALTH CAN	MPUS		JASPE	R, IN47546		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		6 units, 301-350= 8	+	IAU			DATE
	units, and 351-4						
	On 5/24/11 at 1:30 P.M., LPN #2						
		s going to administer the					
		alin for the 11:00 A.M.,					
		At this time LPN #2					
	1	8 units of Novolog					
	insulin.						
	On 5/26/11 at 8:50 A.M., during interview						
	with the Director of Nursing (DON), she						
	indicated sliding scale insulin should be						
	given as ordered	at time of accucheck.					
	2. On 5/24/11 at	t 1:50 P.M., LPN #1 was					
	interviewed rega	arding an insulin injection					
	she had just give	en. LPN#1 at this time					
	indicated she had	d just given Resident #4					
		nits of Humalog insulin					
		sulin) for a 275 accucheck					
		pleted at 11:45 A.M. She					
		d been unable to do the					
		d sugar test) ordered daily					
	at 11:00 A.M. ur	ntil at 11:45 A.M.					
		rrent physician orders					
		t this time and included					
		d 4/1/09, for accucheck					
		d at bedtime 6:00 A.M.,					
		O P.M., and 8:00 P.M A					
		one order dated 4/15/11,					
		ontinue Novolog sliding					
		replace with Humalog					
	sliding scale inst	ulin. The Humalog					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155674	B. WIN			05/27/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEI	₹		3150 S	T CHARLES ST		
	RLES HEALTH CAN			JASPEI	R, IN47546		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	COMPLETION DATE
IAU	+		•	TAG	Berielewery		DATE
		ge was: $60-150 = zero$					
	· ·	= 1 unit, 201 - 250 = 2					
	· ·	= 3 units, 301 - 350 = 4					
		= 5 units, and > 400 = 6					
	units and call ph	ysician.					
	On 5/25/11 at 12	2:20 P.M., during					
	interview with the Director of Nursing						
		cated medications should					
	` ''	as ordered in regard to					
	sliding scale insulin to be given as ordered						
	at time of accucheck.						
	at time of accue	icck.					
	3. On 5/24/11 at	4:00 P.M., during					
		ne medication pass					
		ceived the oral medication					
		Con) (625 mg). After the					
	,	been administered LPN					
		the medication had been					
		dication Administration					
	1 ~						
	, , ,	of today's date, 5/24/11.					
	1	MAR had a line marked					
		ther day's date which					
		edication was to be given					
	every other day.						
	The May 2011 N	MAR indicated, "					
	I	bs Fibercon 625 mg					
	1	orally 2 x/day every					
		er (order date 8/26/10)."					
	1	:11 P.M. Resident #16's					
		vas reviewed related to					
		. A telephone order,					
		cluded but was not limited					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DIFFERENCE 00			(X3) DATE SURVEY COMPLETED		
	or country.	155674	A. BUILDIN B. WING	IG		05/27/20	
	PROVIDER OR SUPPLIER		ST 31	150 ST	DDRESS, CITY, STATE, ZIP CODE CHARLES ST 1, IN47546		
(X4) ID		TATEMENT OF DEFICIENCIES			.,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	to the order: " I po (orally) at 12N	Fiber-Con 625 mg i tab N & supper"					
	On 5/24/11 at 4: 11 P.M., LPN #1 was made aware of physician order dated 3/2/11, which instructed Fiber-Lax was to be given twice a day. On 5/24/11 at 4:20						
	_	dicated the medication					
		en changed on the MAR					
	after the telephor	ne order had been					
	received on 3/2/1	1.					
	The 2011 March	and April MAR					
	indicated the resi	dent received the					
	Fiber-lax medica	tion twice a day every					
	other day.						
	3.1-25(b)(9)						
	3.1-48(c)(2)						
F0387 SS=E	least once every 3	be seen by a physician at 0 days for the first 90 days and at least once every 60					
	occurs not later the						
		review and interview, the	F0387	7	F 387		06/26/2011
	facility failed to	ensure 4 of 4 residents,			Resident # 3, 16, 2, and 37 suffered	no ill	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155674 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3150 ST CHARLES ST ST CHARLES HEALTH CAMPUS JASPER, IN47546 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE reviewed for timely visits, from a sample effects from the deficient practice. All the above residents where seen prior of 12, were seen by physicians every 30 to the state department of health exiting days for the first 90 days of residence the campus. and/or every 60 days thereafter. Resident Completion Date 05/24/2011 #3, Resident #16, Resident #2, and All residents have the potential to be Resident #37 affected by the alleged deficient practice and through alterations in processes will ensure residents are visited by a Findings include: physician once every 30 days for the first 90 days and at least once every 60 days thereafter. 1. The clinical record of Resident #3 was reviewed on 5/23/11 at 2:00 P.M. The Completion 06/26/2011 resident had been admitted on 6/08/10. Systemic change medical records nurse The physician did not visit until 7/29/10. to maintain a tickler system monitoring The attending physician visited 8/30/10 last physician visit to assure residents and 12/09/10, missing the 9/30/10 visit. seen every 30 days for first 90 days and at least once every 60 days thereafter. There were no visits between 2/10/11 and 5/24/11 (missing the visit which was due Completion Date 06/26/2011 4/10/11). DHS or designee will audit tickler 2. The clinical record of Resident # 16 system once a week to assure was reviewed on 5/23/11 at 2:10 P.M. compliance with visits with results being forwarded to QA committee monthly x 6 The resident had been admitted on months and quarterly thereafter for 9/21/05. Documentation was lacking of review and further suggestions/comments. an attending physician visit between Completion Date 06/26/2011 1/12/11 and 5/02/11 (visit due 3/12/11). 3. The clinical record of Resident #2 was reviewed on 5/23/11 at 2:20 P.M. The resident had been admitted on 8/20/10. Documentation was lacking of an attending physician visit from 12/08/10 to 5/24/11 (visit due 2/08/10). 4. The clinical record of Resident # 37

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155674			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/27/2011
	PROVIDER OR SUPPLIER		3150 S	ADDRESS, CITY, STATE, ZIP CODE T CHARLES ST R, IN47546	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	The resident had 2/02/10. Docum an attending phys 1/12/11 and 3/30 5. On 5/27/11 at of Nursing was in timely physician facility had a sys physicians were the delinquent data.	5/23/11 at 2:25 A.M. been admitted on entation was lacking of sician visit between /11 (visit due 3/12/11). 10:30 A.M., the Director interviewed regarding visits. She indicated the tem in place whereby inotified 10 days before te for visits due. She the system had failed to em.			
R0000	3.1-22(d)(1) 3.1-22(d)(2)				
	_	sidential findings were ce with 410 IAC 16.2-5.	R0000	Plan of Correction Text: The submission of this plan of correction does not indicate admission by St Charles Heat Campus that the findings and allegations contained herein an accurate and true representation of the quality care provided to the resident St Charles Health Campus. St Charles Health Campus facility recognizes it's obligated provide legally and medically necesary care and services are residents in an economic and	alth d are of s of This ion to to its

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06/14/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155674 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3150 ST CHARLES ST ST CHARLES HEALTH CAMPUS JASPER, IN47546 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE efficient manner. The facility herby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (for Title 18/19 programs) To this end, this plan of correction shall seve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. R0240 (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. R 240 Based on interview and record review, the R0240 06/26/2011 facility failed to ensure assisitive devices Resident 21 did not suffer any ill effects were in use to prevent falls for 1 of 5 from the alleged deficient practice. residents reviewed for falls in a sample of Completion Date 06/26/2011 5. Resident #21 All other residents are at risk to be affected by the alleged deficiency and Findings include: through alterations in processes and in servicing the campus will ensure assistive devices are used to prevent Resident #21's clinical record was reviewed on 5/26/11 at 1:00 P.M. His Completion Date 06/26/2011 current service plan with a date of 4/25/11, indicated resident was alert and Nursing staff have been in serviced oriented and required physical assistance concerning Fall/Safety Management and use of gait belts for transfers. Systemic for transfers. Diagnoses included, but change is that caregivers will sign A were not limited to: essential tremor and Guidelines for Gait Belt Use Form. right hemiparsis (one side paralysis). Completion Date 06/26/2011 A nursing note dated 12/28/10 at 8:30 P.M., indicated, "Called to Rm (room DHS /designee will monitor 3 random number) @ this x (time) by CNA. Res. resident at risk for falls to assure (resident) was getting into bed c (with) assistive devices are used to prevent falls

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155674	A. BUII	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/27/2011	
NAME OF PROVIDER OR SUPPLIER ST CHARLES HEALTH CAMPUS			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN47546				
ST CHAF (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CNA A(assistance) et lost balance et fell to the side to the floor. Full ROM (range of motion) performed s (without) pain or difficulty. 0(zero) injuries noted" " CNA admits not using gait belt on res. Educated res. to transfer properly. Educated staff on gait belt use et proper transfers" A fall circumstance, assessment and		JASPE ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments Completion Date		(X5) COMPLETION DATE
	P.M., was review indicated the restransferred from the assistance of belt. The preven	a chair to the bed with one staff without a gait tion intervention initiated er counseled on need to					
	manager was inte falls of 12/28/11 indicated that dif	250 A.M., the nurse unit erviewed regarding the and 5/21/11. She ferent staff (CNAs) were dent at the time of the s.					